TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Richard J. Stephenson, D.C.

Respondent Name
American Home Assurance Company

MFDR Tracking Number
M4-10-4867

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 27, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The total amount billed was $ 500.00. The total amount paid by the carrier was $0.00. The total amount in dispute is $ 500.00."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Division Note: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on February 18, 2015. 28 Texas Administrative Code §133.307(d)(1) requires that:

> The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 11, 2009	Referral Doctor Examination to Determine Maximum Medical Improvement & Impairment Rating (99455-V5-W5-NM)	$500.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. Texas Labor Code §408.0041 defines the requirements for a designated doctor examination.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 181 – Payment adjusted because this procedure code was invalid on the date of service.
   - W1 – Workers compensation state fee schedule adjustment.

Issues

Is the insurance carrier's reason for denial or reduction of payment supported?

Findings

The requestor is seeking $500.00 reimbursement for procedure code 99455-V5-W5-NM. The insurance carrier denied disputed services with claim adjustment reason code 181 – "Payment adjusted because this procedure code was invalid on the date of service." 28 Texas Administrative Code §134.204(i)(1) requires designated doctors to include modifier W5 for examinations of maximum medical improvement and impairment rating. Further, modifier W5 is defined in 28 Texas Administrative Code §134.204(n)(20) stating,

> … Designated Doctor Examination for Impairment or Attainment of Maximum Medical Improvement--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of maximum medical improvement.

Review of the submitted documentation does not find that the requestor was a designated doctor as defined in Texas Labor Code §408.0041. In addition, 28 Texas Administrative Code §134.204(j)(2)(A) states,

> If the examining doctor, other than the treating doctor, determines MMI **has not been reached** [emphasis added], the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added.

Review of the submitted documentation finds that the requestor found that MMI was reached. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Even though all the evidence was not discussed, it was considered. For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	February 12, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.